PUBLIX PHARMACY

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Osteoarthritis Referral Form

Publix Specialty Pharmacy (#3212)

7616 Southland Blvd, Suite 112
Orlando, FL 32809
Phone: 855-797-8254
Fax: 863-413-5723

Patient Information [Attach copy of front and back of prescription insurance card(s)]

Patient's First Name: _____ Patient's Last Name: _____ Date of Birth: ___/___/_____ □ Male □ Female

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone Number: (_____) _____ Alt. Phone Number: (_____) _____ Caregiver name: _____

Clinical Information [Attach copy of labs and office notes]

Diagnosis code: □ M17. _____ □ Other: _____ Diagnosis: □ Osteoarthritis of the knee □ Other: _____

NSAIDs: □ Active, name and dose: _____ □ Contraindicated/failed, describe: _____

Steroids: □ Active, name and dose: _____ □ Contraindicated/failed, describe: _____

Other pertinent past medical history and/or drug therapy: _____

_____

Weight: _____ □ kg □ lb Height: _____ □ cm □ in Allergies: □ NKDA □ Other: _____

MEDICATION	DIRECTIONS	DISPENSE QTY FOR
□ Gel-One 30 mg/3 mL PFS □ Monovisc 88 mg/4 mL PFS □ Synvisc-One 48 mg/6 mL PFS	Inject 1 syringe IA into □ LEFT □ RIGHT knee once (to be administered by healthcare professional)	1 dose
□ Hymovis 24 mg/3 mL	Inject 1 syringe IA into □ LEFT □ RIGHT knee once a week x 2 weeks (to be administered by healthcare professional)	2 weeks
□ Euflexxa 20 mg/2 mL PFS □ Gelsyn-3 16.8 mg/2 mL PFS □ Synvisc 16 mg/2 mL PFS	Inject 1 syringe IA into □ LEFT □ RIGHT knee once a week x 3 weeks (to be administered by healthcare professional)	3 weeks
□ Orthovisc 30 mg/2 mL PFS	□ Inject 1 syringe IA into □ LEFT □ RIGHT knee once a week x 3 weeks (to be administered by healthcare professional)	3 weeks
	□ Inject 1 syringe IA into □ LEFT □ RIGHT knee once a week x 4 weeks (to be administered by healthcare professional)	4 weeks
□ Hyalgan 20 mg/2 mL PFS □ Supartz FX 25 mg/2.5 mL PFS	Inject 1 syringe IA into □ LEFT □ RIGHT knee once a week x 5 weeks (to be administered by healthcare professional)	5 weeks
□ Other: _____	_____	_____
□ Other: _____	_____	_____

Prescriber Information [Ship to prescriber: □ No □ Yes, appointment date: ___/___/_____] Use Cover My Meds: □ Yes □ No

Name: _____ DEA# _____ NPI # _____

Address: _____ City: _____ State: _____ Zip: _____

Office Phone Number: (_____) _____ Fax Number: (_____) _____ Office Contact: _____

I authorize Publix Pharmacy representatives to act on behalf of the prescriber to initiate and complete the insurance prior authorization process.

Prescriber's signature: _____ _____

(stamps not accepted) □ Substitution allowed Date □ Dispense as written/ Do not substitute Date

For states requiring hand written expressions to prevent substitution, write here: